DOCUMENT RESUME

ED 321 209 CG 022 658

AUTHOR Landes, David
TITLE What Legislators Need to Know about Long-Term Care Insurance.
INSTITUTION National Conference of State Legislatures, Denver, CO.
REPORT NO ISBN-155516-677-6
PUB DATE May 87
NOTE 29p.
AVAILABLE FROM Marketing Department, National Conference of State Legislatures, 1050 Seventeenth Street, Suite 2100, Denver, Colorado 80265.
PUB TYPE Guides - General (050)

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Financial Support; *Insurance; *Long Term Care; *Public Policy; *State Legislation; State Programs

ABSTRACT

This booklet discusses the potential importance to states of long-term care insurance, describes general policy characteristics, and summarizes state actions to both regulate and promote long-term care insurance. It is intended as a resource for legislators and others involved in long-term care financing and public policy formulation. Long-term care insurance is defined as an emerging private financing mechanism for long-term care services--services that are required due to a chronic illness or a condition lasting over a prolonged period of time. It is noted that currently government payment is available through Medicaid only for the poor or for those who have depleted all their own resources, and that states have begun searching for ways to limit the amount of assets that must be spent before becoming eligible for Medicaid. The answers to the following seven questions are discussed in detail: (1) What are long-term care and long-term care insurance?; (2) Why is long-term care insurance an important issue for state legislatures?; (3) What types of long-term care insurance policies are available?; (4) What are the barriers to the expansion of long-term care insurance?; (5) What have states done to regulate the sale and content of long-term care insurance policies?; (6) What have states done to encourage the sale of long-term care insurance?; and (7) What is the future of long-term care insurance? References are included in 72 end notes. (Author/ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED327209

What Legislators Need to Know About Long-Term Care Insurance

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

R. T. Craig

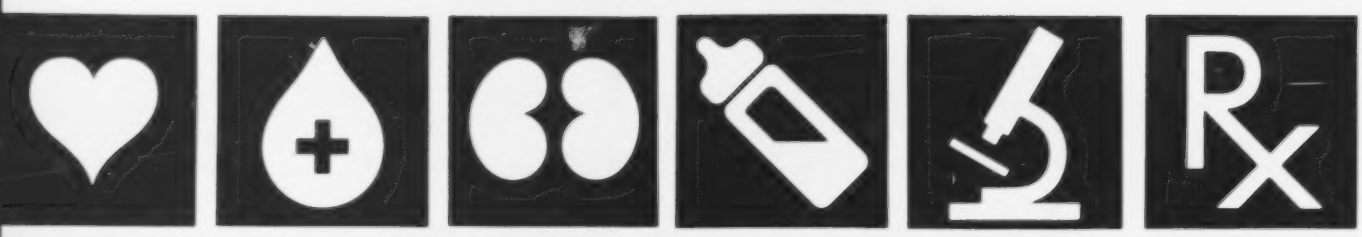
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CG 022658

National Conference of State Legislatures

Foundation for State Legislatures

BEST COPY AVAILABLE



What Legislators Need to Know About Long-Term Care Insurance was written by David Landes, health care program manager, National Conference of State Legislatures (NCSL).

Persons who provided information and who also reviewed drafts were:

Gary Claxton, Ron Hagen, Gail Kirby, Bette Mullen, and Jane Tilly, American Association of Retired Persons; Carroll Wendland, Ph.D. and Glen Duncan, Beverly Foundation; Cynthia Fuller, Florida Department of Insurance/ Treasurer; Alice Clamp, John Mathews, Shirley Nagelschmidt, Susan Van Gelder, and Karen Williams, Health Insurance Association of America; Kim Bellard, Prudential Insurance Company of America; Linda Schofield, Traveler's Insurance Company; and Martha King, Bob Pierce, and Candace Romig, National Conference of State Legislatures.

Others who provided special assistance include:

S. David Childers, Arizona Department of Insurance; John Coniff, Washington legislative staff; Ginny Felice, Massachusetts Special Commission on Elderly Health Care; Senator Helen Garrett, Kentucky; Lawrence Kirsch, Consumer Health Advocates, Inc.; Larry Lane, InSpeech, Inc.; Senator Eric Petty, Minnesota; Roy Ray, Texas State Board of Insurance; Lloyd Rice, Illinois Department of Insurance; Harlan Tanaka, Hawaii Insurance Commissioner's Office; David Walker, Washington Insurance Examiners Office.

Special thanks to Joanne Ourada for typing the manuscript and Sharon Schwoch for editing it.

Preparation of *What Legislators Need to Know About Long-Term Care Insurance* was sponsored by the Beverly Foundation, the Health Insurance Association of America, and the American Association of Retired Persons Women's Initiative. The National Conference of State Legislatures is solely responsible for its content.

May 1987

Copyright © 1987 by the National Conference of State Legislatures
ISBN 1-55516-677-6

Introduction

Long-term care insurance is an emerging private financing mechanism for long-term care services—those services required due to a chronic illness or a condition lasting over a prolonged period of time. Currently, through the Medicaid program, government payment for long-term care is available only for the poor. Individuals not qualifying for Medicaid generally use their own assets until they are exhausted. State governments are searching for ways to reduce the burden of Medicaid expenses and to halt the financial drain on individuals. Long-term care insurance and other private financing mechanisms for long-term care represent a group of possible solutions to the problem.

State governments are also responsible for insurance regulation and consumer protection. Having begun to assess the need for regulation of long-term care insurance, states are finding that such regulation raises some difficult issues. Because long-term care insurance is relatively new, insurers consider it a financially risky venture. Some state attempts to protect consumers and regulate the insurance market raise the possibility that insurers may withdraw from the state rather than operate under conditions of increased financial risk. Each state must balance the need to protect consumers against the possibility of losing any potential benefits of long-term care insurance. States also may want to take action promoting the purchase of long-term care insurance.

This booklet discusses the potential importance to states of long-term care insurance, describes general policy characteristics, and summarizes state actions to both regulate and promote long-term care insurance. It is intended as a resource for both legislators and others involved in long-term care financing and public policy formulation.

Question One: What Are Long-Term Care and Long-Term Care Insurance?

Long-Term Care

> *Long-term care* refers to a broad spectrum of medical and support services provided to persons who have lost some or all capacity to function on their own due to chronic illness or condition and who are expected to need such services over a prolonged period of time.[1]

As used in this booklet, *long-term care* does not include short-term rehabilitative care, whether provided in nursing homes, other institutional settings such as extended care or rehabilitation units of acute care hospitals, or individuals' own homes. In contrast to acute care, long-term care typically requires less technical and intensive medical treatment. Nurses, nurses aides, rehabilitation and other specialists, and persons providing homemaker services play key roles. Physicians are less prominent than in acute care.

There are three different levels of long-term care:

- *Skilled nursing care*–nursing and rehabilitative services given by skilled health personnel on a daily basis, under orders of a physician;
- *Intermediate care*–the same as skilled nursing care, except that procedures may be performed on an occasional basis; and
- *Custodial/personal care*–assistance in activities of daily living that can be provided by persons without medical skills.[2]

Although there is general agreement on the existence of the three levels of care, insurers, government officials, and other groups all define the three levels differently.

All three levels of long-term care can be provided in nursing homes or in patients' own homes. The cost for each type of care, however, may vary by the setting. In 1984, approximately 20 percent of persons receiving long-term care resided in nursing homes, with the remainder living at home. Of those in their own homes, 75 percent were maintained solely through the efforts of unpaid caregivers such as family, friends, and volunteer community workers.[3]

The elderly (over age 65) population, the primary users of long-term care services, will increase in the future. By the year 2000, the number of elderly (over age 65) persons will have increased by 37 percent over the number in 1980.[4] As a percentage of total population, the elderly will increase from 11.3 percent in 1980 to 13.1 percent by 2000.[5] Increasing longevity will swell the over-85 age group, those elderly most likely to need long-term care. The number of persons over age 85 in the year 2000 will be 129 percent higher than the number of persons in the same age group in 1980.[6] It is estimated that on any given day in 1978 22 percent of those over 85 resided in nursing homes, compared with 7 percent of the age 75 to 84 population and only 2 percent of the age 65 to 74 population.[7]

The need for long-term care services will reflect the growth in the elderly population. The number of elderly persons with limitations of activity due to chronic conditions is projected to increase 38 percent between 1978 and 2003, assuming current mortality rates.[8] Should mortality rates

continue to decline, the increase could be as high as 64 percent.[9] Nursing home utilization is projected to rise by between 62 percent and 125 percent in the same time period, depending on whether mortality rates remain constant or decline.[10]

Long-Term Care Insurance

Long-term care insurance is insurance intended to cover long-term care services. The definition of long-term care used in this publication excludes short-term rehabilitative or acute care services. Consequently, the definition of long-term care insurance excludes insurance intended primarily to cover short-term care, such as Medicare supplemental insurance covering Medicare deductible and coinsurance payments. (See Question Four for a complete discussion of the Medicare nursing home benefit.) Existing long-term care insurance policies cover long-term care services exclusively, but long-term care insurance eventually may be sold as part of a more comprehensive health or life insurance package.

Policies now on the market have the following general characteristics:

- Coverage for nursing home care (almost always skilled nursing care, sometimes intermediate or custodial level care) and sometimes for home health care services. Benefits are paid up to a specified maximum number of days, home visits, or dollars, and often are contingent on a prior stay in a nursing home or hospital.
- Indemnity benefit payments. Policyholders receive a specified amount of money per day or per home visit, regardless of the actual expenses incurred. Policyholders then are responsible for paying providers of care, making up the difference between insurance receipts and charges incurred out of their own funds. Some policies escalate the amount of the indemnity payment each year the policy is in force, charging a higher premium for this option.
- Benefit or coverage limitations. Long-term care required for certain conditions, such as alcoholism or mental illness, may be excluded entirely from coverage. Care for other medical conditions diagnosed or treated before the policy is purchased ("pre-existing conditions"), such as heart disease or stroke, may be covered only after a waiting period of between three months and one year. Policyholders generally pay for a minimum number of nursing home days or home health visits before benefit payments can begin ("elimination periods").

Should current policies achieve satisfactory results, insurers can be expected to broaden their offerings to include policies with wider coverage and fewer exclusions and limitations.

Estimates of the number of insurers offering long-term care policies range as high as 35.[11] At least one policy is available in every state. Between 130,000[12] and 200,000[13] policies are estimated to be in effect.

Long-term care insurance helps consumers pay for long-term care by spreading the risks and the costs over large numbers of persons. There also exist two types of asset accumulation programs (not discussed further in this publication) that help consumers generate funds to pay for long-term care services by themselves:

- Asset accumulation programs targeted to health care. These include life insurance with pre-death long-term care benefits and "individual medical accounts" ("medical IRAs") that allow individuals to save their own money to pay for future health care expenditures. These are largely proposals at this time. Only one state, Colorado, has enacted legislation recognizing individual medical accounts,[14] and no insurers currently offer life insurance with long-term care benefits.
- Asset accumulation programs not targeted to health. These include life insurance cash value savings, pension accumulations, and reverse annuity/mortgage programs that allow individuals to convert their equity in real property or other assets into monthly income. These programs supply unrestricted income that individuals may use for any purpose, including health care. All are widely available except for reverse annuities/mortgages, which are available only in certain states and localities.

Accumulated assets also could be used to purchase long-term care insurance rather than long-term care services directly.

Question Two: Why Is Long-Term Care Insurance an Important Issue for State Legislators?

Long-term care insurance has the potential to reduce state Medicaid expenditures by decreasing the number of persons who are forced to rely on Medicaid to pay their nursing home and home health care costs. A major study of private financing of long-term care, conducted by ICF Incorporated for the U.S. Department of Health and Human Services, estimated that long-term care insurance could reduce Medicaid nursing home expenditures by between $3 billion and $9 billion annually over a 35-year period (depending on the assumptions used to estimate how many persons would purchase long-term care insurance).[15] These dollar amounts represent reductions of between 8 and 23 percent in annual Medicaid nursing home expenditures.[16] Another study, done by The Brookings Institution using different assumptions, estimated a maximum average 5 percent reduction in Medicaid expenditures in the years 2016 to 2020.[17] Reductions might increase, however, in subsequent years.

Medicaid expenditures are one of the fastest growing components of state budgets. Between 1975 and 1981, state-only Medicaid costs increased from 5.6 percent of all state expenditures to 7.7 percent.[18] Long-term care expenditures are a significant component of Medicaid expenditures. Nursing home care is the second largest expense in the national Medicaid budget after hospital care, accounting for 37 percent of total state-funded Medicaid expenditures in 1985.[19] Between 1980 and 1985, total Medicaid nursing home expenditures increased from $9.8 billion to $14.7 billion, a 10 percent annual increase, growing faster than any other part of the Medicaid budget except hospital care.[20] The predicted increase in the over-65 population and the especially large increase in the over-85 population are expected to accelerate the rise in Medicaid expenditures.

The present, near-exclusive reliance on Medicaid and private financing for long-term care raises additional public policy concerns about access to care and family impoverishment. In 1985, payments out of personal funds accounted for 53 percent of all long-term care services purchased in nursing homes while Medicaid covered 42 percent.[21] Medicaid recipients may find it difficult to gain admission to Medicaid-certified nursing homes because their operators prefer patients who pay privately, generally at rates higher than those Medicaid pays. This is especially true for patients requiring intensive and technically difficult care and in states where bed supply has been strictly controlled by certificate of need programs. Medicaid recipients are excluded entirely from nursing homes that choose not to be Medicaid certified. Medicaid emphasizes institutional long-term care, and many state programs provide only limited home health care. Finally, the pressure on legislatures to reduce state budgets makes Medicaid recipients vulnerable to future benefit cuts.

Private-pay patients incur nursing home charges that average $67 per day, or nearly $25,000 annually.[22] Many exhaust their resources. One study, using computer simulations, estimated that between 40 and 72 percent of the persons entering nursing homes as private-pay patients would spend down to Medicaid eligibility levels within six months of admission.[23] Between 55 percent and 82 percent would do so within one year of admission.[24] For elderly couples with one spouse in a nursing home, the depletion of assets for long-term care also impairs the remaining spouse's ability to live independently. This problem of spousal impoverishment has been of special concern to state legislators, and states have begun searching for ways to limit the amount of assets that must be spent before becoming eligible for Medicaid.

Question Three: What Types of Long-Term Care Insurance Policies Are Available?

Long-term care insurance is a relatively new phenomenon, and policy offerings will be refined continually over the next few years. While policies on the market differ in a number of ways, they share some general features.

Benefits

Nursing Home Care
Coverage for nursing home care is the principal component of almost all long-term care insurance policies. Generally, a specified dollar amount per day is paid for a maximum number of days (most frequently three or five years) in a state-licensed nursing home. Some policies impose lifetime maximum limits on total days of care paid for or total reimbursement dollar amounts or both. Almost all policies cover skilled nursing care. Some also cover intermediate or custodial level care. Benefit payments often differ by type of facility or level of care.

Most policies include provisions designed to reduce induced demand – the tendency of policyholders to use more services because insurance pays some or all of the costs. These provisions may require, for example, that covered nursing home care be preceded by a minimum length of stay in a hospital (usually three days), or that care be certified by a physician as "medically necessary." Elimination or deductible periods before benefit payments begin serve a similar purpose. Policyholders are discouraged from unnecessary nursing home use, since they must pay the initial charges themselves until benefit payments begin. Elimination periods also screen out nursing home stays intended more for short-term rehabilitation or posthospital recovery.

Adverse selection – the tendency of high-risk or already-ill persons to seek insurance – is reduced by applicant screening, which all insurers writing individual policies have the right to do. Many policies exclude coverage for alcoholism, mental retardation, or mental illness not of organic origin. For insurers, these exclusions represent high-risk coverages since they are difficult to define in an insurance policy and use of services is difficult to manage effectively. Other pre-existing conditions (conditions diagnosed or treated prior to purchase of the insurance), such as a recent stroke or diagnosed Alzheimer's disease – the existence of which could encourage already-sick individuals to seek insurance, generally are covered only after a waiting period, typically six months.

Home Health Care
Some policies cover home health care. Home health coverage is not universal because insurers are less able to protect themselves against adverse selection and induced demand. There is no general agreement on the services included in home health care and the need for such care is more difficult to judge objectively. Policies covering home health care differ in the scope of covered services. Some cover only those services provided by licensed health care personnel: rehabilitation services such as physical, speech, and occupational therapy; and nursing services

such as injections, wound dressing, and intravenous fluid administration. Policies with broader coverage also may include personal care services intended to assist with activities of daily living: bathing, routine physical exercise, walking, eating, and monitoring of medication use.

All policies limit the number of home health visits or days of home health care covered. Most policies include provisions to guard against adverse selection and induced demand similar to those applied to nursing home benefits. Use of home health benefits may be contingent on a prior nursing home stay, for example.

Payment Mechanisms and Premiums

Individuals who have purchased long-term care insurance have done so at about the same time they perceived the need – in middle to late life. Policies typically have a minimum age of 55 or 60.[25] If clients would purchase at a younger age, insurers could reduce annual premiums since they would have a longer payment period to build up funds to pay benefits. However, since even elderly individuals often do not see the need to purchase long-term care insurance (see Question Four), purchase by younger individuals does not appear likely without employer-sponsorship or changes in public attitudes.

Long-term care insurance premiums vary depending on the policyholder's age. "Level premium" policies have premiums that are determined by the policyholder's age at the time of purchase and remain the same as long as the policy remains in effect. "Graduated premium" policies increase the annual premium as the policyholder ages. Premiums for these policies are lower for younger individuals than those of the level premium policies but are higher for older persons. In addition to age, scope of covered services, the length of elimination periods before benefits can begin, the length of time benefits will be paid, and the amount of the daily benefit payment all influence the premium amount. Insurers often reserve the right to increase premiums for whole classes of policyholders based on changes in benefit utilization. A comparison of nine relatively comprehensive policies published in March 1986 showed that monthly premiums ranged from $28 to $37 at age 55 to from $106 to $148 at age 75.[26]

Most long-term care policies are sold on an individual, rather than a group, basis. Experts generally agree that premiums would decrease with a shift to group long-term care insurance. Group insurance covers larger numbers of persons allowing insurers to spread the risks more broadly and offering greater protection from adverse selection. Most group insurance, however, is employer based, and numerous obstacles exist to offering long-term care insurance as a component of employers' benefit packages.[27] Younger employees generally are not interested in long-term care insurance, preferring more immediately useful benefits such as longer vacations. Court decisions and existing legislation may restrict an employer's ability to alter benefits of current retirees, limiting the freedom to reallocate funds to new benefits for active workers. Tax laws do not provide favorable tax treatment for the expenses of pre-funding retiree health benefits such as long-term care insurance. Finally, accounting standards soon may require companies to show unfunded retiree health benefits as balance sheet liabilities. Long-term care insurance benefits for retirees ultimately could cost much more than expected given the difficulty of accurately estimating future expenses of providing such care. Despite these obstacles, some employers are considering long-term care insurance benefits for employees.

Combining Long-Term Care Insurance with Other Forms of Insurance

While existing long-term care insurance policies cover long-term care exclusively, there is no reason why long-term care insurance could not be part of a broader life or health insurance policy. An experimental program offering both acute care and long-term care services on a capitated basis is being tested in four locations (Long Beach, California; Portland, Oregon; Minneapolis, Minnesota; and Brooklyn, New York), with technical assistance paid for by the U.S. Department of Health and Human Services. Labeled "social" health maintenance organizations (S/HMOs), these are traditional medical HMOs that also provide long-term care (nursing home, home health) and social services (homemaker and case management services) to Medicare beneficiaries for limited amounts of time. S/HMOs combine insurance and service provision in a single entity. Since S/HMOs must provide all necessary services for a set monthly fee, they have a strong incentive to provide services in the most cost-effective manner. This could mean substituting less expensive nursing home care for hospital care, and home care for nursing home care, wherever possible. The S/HMO structure also should help control induced demand. Since the S/HMO controls access to care, it should be able to manage and coordinate service use and reduce inappropriate utilization. Since these experimental programs only began operation in 1985, it is too early to judge their success. Should they succeed, however, capitated systems will offer another mechanism for combining long-term care financing and services with acute care and Medicare supplemental benefits in a managed care environment.

Life care communities, in which persons are guaranteed a lifetime residence and long-term care services in return for an initial payment and continuing monthly fees, are a form of long-term care insurance. Some life care communities provide nursing home and home health services using their own employees; others contract with outside entities for the provision of services. In 1984, between 55,000 and 100,000 persons nationwide were believed to reside in life care communities.[28]

Long-term care insurance also could be incorporated into a life insurance policy. Policyholders generally would begin paying premiums at a younger age than current long-term care insurance purchasers. Policy benefits would be similar to those available under existing life insurance policies, except that a long-term care insurance coverage option would be available at the time the policyholder chose to begin benefit payments. A number of insurers are developing such policies. A first step in this area is the Office of Personnel Management's recent proposal that certain older federal employees be allowed to convert a portion of their life insurance to long-term care insurance.

Question Four: What Are the Barriers to the Expansion of Long-Term Care Insurance?

Barriers to the expansion of long-term care insurance exist both among potential purchasers and among insurers. Elderly consumers often do not see a need for long-term care insurance or believe they already are covered in the event they need to use long-term care services. At the same time, many insurers view long-term care insurance as risky and potentially unprofitable, given the nature of the product and the absence of historical experience on which to calculate premiums. Governmental actions (discussed in Question Five) also have influenced the availability of long-term care insurance.

Consumer Disinterest Toward Long-Term Care Insurance

Among the over-55 population, the rate of purchase of long-term care insurance is low. Of a potential market of approximately 50 million persons over age 55 in 1985, only 0.3 to 0.4 percent had such coverage. If long-term care insurance is to become a viable financing mechanism for long-term care, the reasons for this low rate of purchase must be understood.

Market research data do much to explain consumers' low level of interest. The findings of two surveys are especially relevant: the Long-Term Care Insurance Survey, a 1982 six-state survey of 1,403 elderly persons done by the National Center for Health Services Research; and the American Association of Retired Persons (AARP) Survey of 1,009 AARP members nationwide, done by the Gallup Organization in 1984.[29]

The research data indicate that many of the beliefs and expectations of the elderly that discourage purchase of long-term care insurance are incorrect. A common misconception concerns the probability of needing long-term care services in later life. Long-Term Care Insurance Survey results indicate that older persons may underestimate the likelihood of needing nursing home care. While 24 percent of the respondents believed that the average person in their age group was "very likely" to require long-term care in the future, only 15 percent believed it "very likely" that they themselves would ever need long-term care.[30] By contrast, some researchers estimate the likelihood the average person age 65-69 will ever use at least one day of nursing home care to range from 31 percent for men to 52 percent for women.[31]

Survey results also show that the elderly are not thoroughly familiar with existing insurance benefits, believing that Medicare will pay for most long-term care services. Among respondents to the AARP Survey who believed they would need long-term care, 79 percent believed Medicare would pay all or part of their nursing home charges.[32] In fact, Medicare coverage criteria are very stringent: no more than 100 days of skilled nursing care in a Medicare-certified skilled nursing facility following a three-day minimum hospital stay, and then only when a physician certifies that the patient requires skilled nursing care. Consequently, the average covered nursing home length of stay for Medicare patients in 1980 was less than 30 days, compared with an average length of stay for all patients of 456 days.[33] Medicare pays in full only the first 20 days of nursing home care; the beneficiary must pay the first $65 (in 1987) in charges for each of the remaining 80 days. As a result, Medicare's role in long-term care delivery is insignificant. Medicare accounted for only 2 percent of total payments to nursing homes in 1985.[34] Only about 30 percent of

all licensed nursing homes in the United States were certified to accept Medicare patients in that year.[35]

Additional data confirm the relative lack of knowledge about insurance coverage. Only 33 percent of the Long-Term Care Survey respondents were considered to have "solid" knowledge of their Medicare benefits, based on answers to a set of six Medicare-related questions.[36] AARP Survey respondents overestimated their insurance coverage for long-term care; 35 percent believed their insurance policies covered long-term care, when in fact they did not.[37]

Underlying attitudes toward long-term care also may play a role in consumers' reactions to long-term care insurance. A more psychologically oriented study found that individuals viewed contingency planning for long-term care as "an overwhelming, solutionless problem."[38] Study participants felt they were unable to plan for the future because they had little control over future events and because they had little credible information about the costs of long-term care and ways to meet those costs.

Some have argued that the availability of Medicaid may discourage the purchase of long-term care insurance since older persons willing to "go on welfare" will not buy the insurance. There are contradictory findings on attitudes toward welfare. The AARP Survey showed that 62 percent of the respondents considered it acceptable for someone (not necessarily themselves) to accept Medicaid benefits when all other assets had been exhausted.[39] This attitude was more common among younger respondents. Only 19 percent of the elderly in the Long-Term Care Insurance Survey, however, indicated that the availability of Medicaid would prevent them from purchasing long-term care insurance.[40]

A 1984 study of 1,000 members of the "prime life" generation, those age 50 to 64, showed disparate attitudes about responsibility for payment of nursing care after age 65. While 35 percent of the respondents believed individuals had that responsibility, 31 percent believed the responsibility rested with government. Twenty percent indicated that responsibility should be shared.[41]

Another consumer-related deterrent to the growth of long-term care insurance has been the relatively high cost of premiums compared with the average income of the elderly population. Many of the elderly have relatively low incomes, leaving little after costs of food and shelter have been met. What discretionary funds are available for health care usually go for Medigap insurance and noncovered items such as pharmaceuticals and eyeglasses. Thus, some elders may not have enough income to pay long-term care insurance premiums.

Insurer Disinterest in Long-Term Care Insurance

Until recently, there was relatively little interest in long-term care insurance among insurance companies and few policies were available. Insurers generally regarded long-term care by its very nature to be an uninsurable risk, for a number of reasons:

- Individuals' future use of long-term care services is difficult to predict because the factors that influence such use are difficult to measure and quantify. Medical and physical conditions alone do not determine use of long-term care services. Of two persons with the same level of physical or medical disability, only one actually may seek formal long-term care services. Personal preference, availability of family and other social support networks, financial status, and other variables all influence a person's decision to seek long-term care services. Insurers cannot measure these factors accurately and thus find it difficult to calculate the risk of individuals' using long-term care and to determine appropriate premiums.
- Long-term care itself is difficult to define for insurance purposes. Should routine help with bathing

and dressing at home be considered long-term care services? What about nursing home care provided during a three-month recovery from a broken hip? Lack of a clear definition of long-term care makes it difficult to calculate risks to the insurer accurately.

- Adverse selection is more difficult to control in the case of long-term care because of the difficulty of predicting who will use long-term care services. The lower cost of insurance compared with the actual cost of health care, however, can be maintained only if adverse selection is controlled and a relatively small proportion of policyholders actually use benefits. Insurers' failure to limit adverse selection may result in financial losses since long-term care is relatively expensive and also may force premiums up to unaffordable levels.
- Induced demand increases the use of long-term care services. This problem would be most severe for noninstitutional services, where judging appropriateness of services is most difficult. As with adverse selection, uncontrolled induced demand would result in greater than expected utilization of services and possible financial losses for insurers.
- Establishing policy coverages and corresponding premiums in the present for benefits that may be paid far in the future can be risky without reliable historical data. An individual purchasing a policy at age 55 may not collect benefits until age 75 or 80. Future changes in circumstances, such as use of more nursing home care and less home health care, can have a large negative impact on insurers in the future.

Indeed, one of the greatest barriers to insurer participation has been the lack of reliable data on which to base product development and premium-setting decisions. Two types of data in particular are lacking: data on the need for, and use of, long-term care services in the population as a whole, especially in an insured environment; and studies of attitudes and desires of the elderly population.

The first type of data – information on the use of nursing home and home health services by various population groups over time – is needed for pricing long-term care insurance products. Insurers also need more information on the factors that cause persons in need to seek long-term care services so they can calculate the risks of service use accurately and price the premiums accordingly. Such data are not readily available now.

The potential value of the second type of data is illustrated by the AARP Survey. In that survey, 77 percent of the respondents said they would prefer a long-term care plan covering home health care to one covering nursing home care.[42] Yet, home health care benefits are not universal. Such studies are indispensable if products acceptable to the buying public are to be brought to the market.

Reducing Barriers to Long-Term Care Insurance

A number of steps must be taken if the barriers among consumers and insurers are to be reduced. Education and information programs will be needed to increase consumers' awareness and understanding of current long-term care financing mechanisms and the potential role of long-term care insurance. Among insurers, recent events already have stimulated interest in the long-term care insurance concept. Insurance companies have recognized the older population as a potentially profitable new market due to its increasing numbers and affluence (see Question Seven). Insurers are beginning to recognize that while long-term care may be a difficult risk to insure, there may be ways to counteract adverse selection, induced demand, and other uncertainties that threaten the financial viability of long-term care insurance. Finally, insurance companies and government will need to begin collecting the necessary market research and utilization data. The end result should be policies constructed and priced to better meet the expressed needs of consumers.

Question Five: What Have States Done to Regulate the Sale and Content of Long-Term Care Insurance Policies?

To date, few states have enacted laws regarding the sale or content of long-term care insurance policies specifically. Several others have seen some legislative activity but no significant enactments. Still others have initiated studies in the legislative or executive branches to make recommendations regarding long-term care insurance. States with studies in progress or completed are Alaska,[43] Arizona,[44] California, Connecticut, Florida, Georgia,[45] Hawaii,[46] Massachusetts,[47] North Carolina, Texas, and Virginia (citations are given for completed studies only).

The states have primary responsibility for overseeing most activities in the insurance market. The McCarran-Ferguson Act of 1944 affirms the primacy of the states in regulating the insurance industry and limits federal government activity. Generally, state regulation is performed by agencies of the executive branch using statutorily delegated authority to promulgate necessary rules and regulations.

Consumer protection has been the driving force behind state actions to regulate long-term care insurance. State regulation has focused on two areas: the manner in which policies are sold to consumers and the financial attributes of policies and insurers ("performance-based" aspects of the insurance policies); and the specific provisions contained in the policies being sold ("product-based" aspects).

The National Association of Insurance Commissioners (NAIC) recently published a Long-Term Care Insurance Model Act intended to serve as a basis for state regulation of long-term care insurance. The model act relies on both performance-based and product-based regulation.[48]

The following discussion of state regulatory actions is not intended to be a complete listing. Rather, it describes sample enactments and proposals representing approaches to long-term care insurance regulation. Provisions of the model act also are discussed.

Regulating Performance-Based Aspects of Long-Term Care Insurance

Insurance regulators in all states are empowered to promulgate regulations protecting purchasers of insurance. As a result, numerous performance-based requirements intended to protect all purchasers, including those who buy long-term care insurance, already exist. These generally cover:

- Authorization of insurance companies to sell insurance in a state;
- Licensure of insurance salesmen;
- Approval of specific policy wording and format for understandability;
- Disclosure of policy benefits and limitations;
- Specification of conditions under which buyers may return previously purchased insurance (termed "free look" provisions);
- Review of advertising and marketing materials;

- Required notification of rate changes;
- Imposition of financial solvency and reserve requirements to assure that insurance companies can meet future obligations to policyholders.

In addition to these generic consumer protections, some states have enacted or proposed specific measures applicable to long-term care insurance. A common action, derived from existing insurance regulation, is the establishment of minimum loss ratios for policies. A loss ratio is the proportion of premium income from a particular type of policy projected to be ultimately paid back to policyholders in the form of benefits. The lower the loss ratio, the more premium income the insurance company retains for operating expenses and profit. Establishment of a minimum loss ratio attempts to assure that premiums will be fairly and reasonably related to the cost of benefits by making certain that a minimum portion of every premium dollar received will be paid out in benefits. Connecticut and Minnesota have established minimum loss ratios for long-term care insurance by statute: 55 percent and 60 percent, respectively, for individual policies, and 60 percent and 65 percent, respectively, for group policies. Maine and Washington have elected to give authority to insurance regulators to set minimum loss ratios by regulation.[49] The model act allows regulators to prescribe minimum loss ratios as long as they are specifically for long-term care insurance.

Minimum loss ratios have been opposed by the insurance industry because the proposed ratios generally are higher than the industry believes is warranted, given the level of risk and uncertainty in pricing involved. Because long-term care insurance is relatively new, insurers argue, there is no experience on which to base judgments about appropriate loss ratios. Also, imposition of unreasonable loss ratio requirements during the next 10 to 20 years of long-term care insurance "start up" could prevent insurers from building up the reserves necessary to pay future claims. Low loss ratios will occur because the majority of today's purchasers will not begin to claim benefits until 10 or 20 years from now, and insurers will be collecting premiums in anticipation of future benefit payments but paying relatively little in benefits. Insurers claim that the result would be long-term financial losses and that they might have to withdraw from the market rather than run the risk of selling potentially unprofitable policies.

Limiting insurers' ability to cancel policies has been another common legislative action. Minnesota and Washington prohibit cancellation of policies except in the case of nonpayment. South Dakota has considered, but not passed, similar legislation. The model act prohibits cancellation of policies for reasons of age or health status.[50] Advocates of noncancellation provisions argue that it is unfair to allow policyholders to pay premiums for years only to have the policies cancelled in later life when benefits are most likely to be paid.

In another type of consumer protection action, Washington prohibits sale of long-term care insurance policies to persons already receiving Medicaid assistance. This action was taken in an effort to stop the unethical practice of knowingly selling insurance policies to persons who do not need them.

Regulating Product-Based Aspects of Long-Term Care Insurance

As with performance-based regulation, the goal of product-based regulation has been consumer protection. Product-based regulation has caused more controversy, however, than performance-based regulation because its potential impact on market development and on the financial condition of insurers is greater.

Product-based regulation has focused on requiring minimum benefits for long-term care insurance policies and prohibiting inclusion of certain provisions. Examples of minimum benefit provisions either approved, or considered but not approved, include:

- Minimum daily payments for nursing home or home care.

  In Minnesota, the statutorily prescribed minimums are $40 to $60 per day for nursing home care and $20 to $25 per day for home care.[51] Other unsuccessful state proposals would have tied the minimum payments to other indicators. New Jersey would have required that the daily home care benefit equal 75 percent of the daily nursing home benefit.[52] Kansas would have mandated that the daily nursing home benefit be no less than 75 percent of actual charges.[53]

- Coverage of specific services.

  Kentucky requires that skilled, intermediate, and custodial care all be covered by at least one policy offered by each insurer. A number of states have proposed that specific services be covered, such as respite care ("short-term" long-term care intended to give family members a break from attending elderly relatives at home) and home care. Maryland indirectly addresses long-term care coverage by requiring health insurers to offer optional coverage for Alzheimer's disease, the later stages of which require long-term care, and any other care required by the elderly and mandated by the insurance commissioner.[54]

- Minimum numbers of nursing home days or home care visits.

  Kansas and New Jersey considered, but did not pass, such provisions. Kansas proposed a two-year minimum for nursing home benefits; New Jersey, a three-year minimum.

Some states have enacted, or have considered but not enacted, prohibitions on certain policy provisions. These include:

- Prohibiting deductible or copayment amounts above specified levels.

  Minnesota limits copayments to 20 percent of actual charges. Kentucky requires insurers to offer at least one policy with copayments no more than 25 percent of actual charges.

- Prohibiting exclusion from coverage of pre-existing conditions for longer than specified maximum times.

  Generally, medical conditions that were diagnosed or treated within a specified time immediately prior to commencement of the policy are excluded from coverage for a specified time period immediately following commencement of the policy. Washington law specifies that only medical conditions that were diagnosed or treated within one year prior to policy commencement can be excluded, and then only during the first six months following commencement. The model act uses standards of "two years before commencement-two years after commencement" for policyholders under age 65 and "six months before commencement-six months after commencement" for older policyholders. An unsuccessful South Dakota proposal would have limited the definition of pre-existing conditions to only those for which treatment was received within six months prior to the effective date of the policy. This proposal would have prohibited exclusion of coverage for conditions present but not treated in the six-month period.

- Prohibiting the requirement of a prior stay in a hospital as a condition of nursing home benefit payments.

  Kentucky has enacted this prohibition and also proscribes requiring prior care at the skilled nursing level as a condition of

payment of benefits for intermediate level nursing home care.[55] Kansas and New Jersey considered, but did not enact, such a provision.[56]

The practices targeted by these prohibitions are those used by insurance companies to protect themselves from adverse selection and induced demand. The public, however, sometimes sees them as ways of unfairly preventing policyholders from claiming benefits to which they are entitled.

States that have acted to regulate the content of long-term care insurance policies have taken a variety of approaches in allocating responsibility between the legislative and executive branches of government. Kentucky, Minnesota, and Washington have enacted relatively extensive and specific statutes, leaving less discretion to regulators.[57] On the other hand, Maine statutes delegate all regulatory authority to regulators.[58] Some states, such as Arkansas and Wisconsin, have enacted no statutes, but insurance regulators have used existing authority to promulgate long-term care insurance regulations.

Regulation of policy content has been controversial. Proponents argue that the state is obligated to protect consumers from the sale of insurance policies that do not provide meaningful benefits. The elderly, the primary target of long-term care insurance marketing, are particularly vulnerable to deceptive and misleading sales practices. They are not always well informed about the long-term care delivery and financing system or its associated costs. The highly publicized fraud and abuse associated with Medigap policies are cited as a reminder of what can happen when states fail to safeguard the interests of the elderly population. For all these reasons, proponents claim, it is necessary to set minimum benefit levels and prohibit certain provisions, thus preventing the sale of inadequate policies that do not provide the coverage for which consumers believe they have paid.

Opponents of product-based regulation claim that state prescription of policy content limits the flexibility of insurers to adapt their offerings to changing market conditions. Persons desiring relatively low benefit levels or only one kind of coverage, such as nursing home or home health care, will be forced to pay higher premiums for coverage they do not want. Low-income persons may have to do without insurance entirely because they cannot afford the higher premiums insurers must charge for the state-mandated minimum benefits. A second argument is that development of long-term care insurance currently entails excessive financial risk and that imposition of minimum benefit levels and other regulatory requirements will discourage insurance companies fearful of future financial losses. The end result will not be consumer protection but nonavailability, or limited availability, of long-term care insurance.

The States' Experience with Long-Term Care Insurance Regulation

The experience of states that have attempted to regulate long-term care insurance indicates that insurers are highly sensitive to some statutory or regulatory requirements that pose potential financial risks. In general, the insurance industry has supported performance-based regulation. The Industry Advisory Committee on Long-Term Care of the National Association of Insurance Commissioners supported a position of "regulatory flexibility," but with consumer protection safeguards.

Most problems have arisen when states have acted to regulate policy content. An extreme example occurred in Wisconsin. The insurance commissioner, motivated by complaints from policyholders failing to receive benefits to which they believed they were entitled, decided that existing regulations did not protect consumers

sufficiently. He concluded that the most effective way to reduce the number of complaints was to require all policies to provide a minimum level of benefits and to prohibit certain policy provisions limiting benefits. Consequently, the commissioner issued a relatively stringent set of regulations that, among other things, prohibited use of a prior hospital stay as a precondition for payment of nursing home benefits and required insurers to pay for all days of care certified only as "necessary," rather than as "medically necessary." To the insurers, this meant paying benefits for long-term care services that might be necessary for nonmedical reasons, such as social isolation, in addition to those services required due to illness or accident. These requirements increased the likelihood of induced demand since the need for long-term care due to nonmedical factors is difficult to judge objectively or to predict with any reliability. The result was that all but one insurer discontinued sales of long-term care policies in the state, and this insurer did not market this policy actively. The state now has promulgated a revised set of regulations.

Whether Wisconsin and other states are better off with more stringent regulations and fewer insurers or more liberal regulations and more insurers, is a question for each to decide individually. Wisconsin policymakers apparently concluded at the time that it was preferable to have a small number of "good" policies available rather than a large number of policies that did not meet policyholders' expectations. In other states, the opposite may be the case. What the Wisconsin experience demonstrates is that states face difficult tradeoffs in considering proposals to regulate long-term care insurance.

States must balance consumer protection against insurers' avoidance of markets where they perceive inordinate financial risk. State studies of long-term care insurance have emphasized finding a middle ground where consumers are adequately protected and insurers still are willing to offer a variety of coverage. The Arizona and Georgia study commissions recommended no restrictions on long-term care insurers beyond already-existing consumer protections. Although the Massachusetts study called for minimum benefits, they were similar to those already offered in many existing policies. The authors also suggested requiring some policy features but avoided conditions they considered especially onerous to insurers, attempting to leave them free to experiment with new policy features. The National Association of Insurance Commissioners has published a model act intended to balance the interests of consumers and insurers.[59] The model act approach has the advantage of assuring uniformity of both performance-based and product-based requirements from state to state.

Federal Support of State Efforts

Despite lack of direct involvement with insurance, the federal government is interested in long-term care insurance. There have been numerous suggestions for extension of Medicare coverage to long-term care, and long-term care insurance is a potential private sector substitute. Also, budgetary reductions in Medicaid could result from widespread acceptance of long-term care insurance. The federal government has supported a number of research efforts and feasibility studies on long-term care insurance. The recently passed Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA, Section 9601) established the Task Force on Long-Term Health Care Policies to develop recommendations regarding consumer protection, consumer education, and promotion of long-term care insurance. The task force's report will be completed by August 1987.

Question Six: What Have States Done to Encourage the Sale of Long-Term Care Insurance?

States have taken little concrete action to encourage purchase of long-term care insurance. State actions that have been taken have been of two types: requiring insurers to offer long-term care insurance, and encouraging market development through incentives and consumer education. State actions involving requirements have mandated that all insurers offering health insurance also offer coverage for some long-term care services, either as a standard benefit or as an option. Kentucky requires all insurers – individual and group insurers, HMOs, and Blue Cross plans – issuing health policies to make available at least one long-term care policy.[60] Unsuccessful bills in Kansas, Massachusetts, and New Jersey have contained similar requirements. While this kind of requirement may increase the number of insurers offering long-term care coverage, policies offered might not be appealing to consumers. Critics argue that most insurers, fearing financial losses in long-term care insurance, will design unattractive policies with limited benefits and high premiums. Others may withdraw from the state. The upshot would be only a small increase in the number of policies sold and public dissatisfaction with long-term care insurance.

Other states have focused on encouraging long-term care insurance. New York has sought to promote policy availability by giving the superintendent of insurance power to "modify or suspend" certain statutory or regulatory requirements for experimental long-term care insurance policies.[61] Other states have taken more specific actions. These include:

- Preferential Tax Treatment for Long-Term Care Insurance Premiums

  Tax incentives to encourage particular actions are a common strategy in many situations. In 1986, Colorado enacted an income tax deduction for long-term care insurance premium payments for policies meeting specified minimum benefit criteria.[62] An unsuccessful Hawaii proposal would have allowed a tax credit equal to twice the amount of long-term care insurance premiums.[63] Tax incentives were rejected by Arizona's study commission, however, which argued they might hinder development of other incentive programs that would accomplish the same objective without reducing state tax revenues. No action has been taken at the federal level to give preferential treatment to premium expenses on federal income taxes.

- Premium Tax Reductions for Companies Selling Long-Term Care Insurance Policies

  Reductions in premium taxes for long-term care insurance policies could encourage purchasers if part of the savings were passed on in the form of lower premiums. Lower taxes on long-term care insurance premium income also would encourage insurers to sell more long-term care policies since the premium income would be taxed at a lower rate. Colorado has been the only state to take this step, enacting a one percentage point tax reduction on long-term care insurance premium income.

- Consumer Education About Long-Term Care Insurance

  Consumer education programs on long-term care insurance are a frequently mentioned market development strategy. Such programs encourage wise buying and address consumer misconceptions about long-term care and its costs. Long-term care insurance studies in Arizona and Georgia have emphasized the importance of consumer education. The Washington state Insurance Commissioner's Office has established a separate senior citizens' program unit to oversee the state-sponsored Senior Health Insurance Benefit Advisors (SHIBA) program. Working through trained elderly volunteers, the SHIBA program conducts public meetings and media campaigns to educate elderly consumers about a range of insurance-related topics, including long-term care insurance. Topics covered include Medicare and Medicaid eligibility and program benefits, as well as comparison of available long-term care insurance policies. SHIBA also publishes a number of consumer guides for the elderly.

  Additional materials from which states might draw in formulating consumer education programs are also available. A report prepared for the Massachusetts insurance commissioner contains a draft "Guide to Long-Term Care Insurance" describing Medicare and Medicaid benefits, materials to aid prospective purchasers in evaluating the adequacy of benefits, and a proposed disclosure statement to be given to purchasers explaining policies in uniform language.[64] The report done for the National Association of Insurance Commissioners by an advisory committee of insurance industry representatives also contains a model consumer education booklet.[65] The booklet discusses topics similar to those covered by the Washington program. It also has a list of "Questions to Ask [About Long-Term Care Insurance]" and a glossary of long-term care terms. The American Association of Retired Persons also has prepared a consumer's guide to long-term care entitled "Making Wise Decisions For Long-Term Care."[66]

- Removing Barriers to Long-Term Care Insurance Availability

  State laws written prior to the advent of long-term care insurance sometimes create unintentional barriers. Failure to define long-term care insurance as a separate category of insurance may cause it to be considered a form of disability, Medigap, or other supplemental insurance. The result may be the application of inappropriate regulatory criteria and discouragement of interested insurers. Minnesota prohibited sale to Medicare beneficiaries of all health or accident insurance except Medigap policies in an attempt to eliminate the sale of duplicative insurance policies to the same person. This prohibition made the sale of long-term care policies effectively illegal, however, an obstacle that was removed recently.

  In some states, statutory definitions of group insurance may not include the insurance offered by HMOs and Blue Cross plans, making it impossible for them to offer long-term care insurance on a group basis. The public, however, may best be served by a wider selection of policies.

  Legislators may want to review state statutes and reconsider those that restrict development of long-term care insurance. An unsuccessful

South Carolina proposal would have required the Department of Insurance to conduct a review of state regulations to be sure none discouraged long-term care insurance. The Arizona study commission conducted such a review and concluded that no additional laws or statutory revisions were necessary to encourage long-term care insurance. Review of the NAIC model act also may be useful in this regard.[67]

- State Catastrophic Coverage for Long-Term Care Insurance Purchasers

  While not yet introduced as legislation, a proposal from the Massachusetts Special Commission on Elderly Health Care is noteworthy.[68] Under the proposal, the state would agree to assume financial responsibility for persons who purchase Medigap and long-term care insurance with specified minimum benefits, but who exhaust their benefits while receiving long-term care. No asset "spend-down" or other financial requirements would be imposed. Consumers would be encouraged to purchase long-term care insurance since they would be guaranteed future state protection without having to spend down their own funds when their insurance benefits ended. The state would benefit from substitution of private insurance coverage for Medicaid and postponement of Medicaid responsibility for payment. Whether this program is to be implemented through Medicaid or through some other program will depend on interpretation of existing Medicaid program regulations. The advantages and disadvantages of such a plan in terms of access, quality of care, and cost to both consumers and the state are yet to be explored fully. A successful program of this nature, however, might hasten the spread of long-term care insurance by creating a large customer base and stimulating market entry by more insurers.

- State Participation as a Long-Term Care Insurer

  States could act as insurers when private insurance is not widely available. An unsuccessful California proposal would have created a Long-Term Care Association within state government to issue a long-term care insurance policy offering benefits specified in the statute.[69] The policy was intended specifically to supplement policies already available to consumers. It would have covered intermediate, personal, and home care, but not skilled nursing care, which generally is covered by policies now on the market.

- Long-Term Care Insurance Benefits for State Employees

  An additional proposal is for states to purchase long-term care insurance for their own employees and retirees. As pointed out in Question Three, however, legal and practical obstacles must be overcome if employers, including the states, are to offer long-term care insurance.

Question Seven: What Is the Future of Long-Term Care Insurance?

Long-term care insurance has a definite role to play in financing long-term care. The demand for long-term care services will increase in the coming years, and government and personal funds alone may be inadequate to pay the costs. A range of new funding mechanisms will be necessary, and long-term care insurance is important among these. Although it has achieved wide visibility only recently, there is growing interest on the part of insurers, consumers, and government. All three groups have incentives to promote its use, but all three groups must take action if long-term care insurance is to play a significant, meaningful part in the nation's long-term care financing scheme.

Insurers

Insurers see a new market for insurance in the growing over-55 age group. Between 30 and 40 companies currently offer long-term care insurance policies. Many more are developing policies for introduction in the next few years. Over 20 Blue Cross plans also are considering offering long-term care coverages. All this activity clearly indicates that insurer interest in long-term care insurance will continue to grow.

But the increased interest among insurers is accompanied by widespread uncertainty about the ultimate financial viability of long-term care insurance. Long-term care is difficult to insure by its very nature. There is little agreement on exactly what constitutes long-term care or on the definitions of the three levels of care. The probability that persons will use long-term care services is not easily calculated, and adverse selection and induced demand are difficult to control. In addition to the inherent difficulties in insuring long-term care, there exist little historical data on which to calculate risks and price premiums. All these factors increase insurers' financial risks.

Insurers temper their interest with words of caution:

> Long-term care insurance is in an embryonic state of development and as yet, it is not known which policy designs might work best. Established carriers are entering this market but products are in an evolutionary stage. The challenge of insurers is to establish benefit levels and premium charges in products which minimize insurance induced demand for services and adverse selection, which avoid stimulating increased provider charges, and which provide meaningful benefits to consumers.[70]

Consumers

Existing long-term care financing alternatives do not always meet the needs of consumers well, so they have been motivated to seek other ways of financing long-term care. Individuals needing such care now must become Medicaid recipients immediately, or they must deplete most or all of their own assets on long-term care expenditures. Medicaid, however, provides little financial support for those desiring home health care, and consumer choice in selection of a nursing home is restricted. Those who must spend down their own funds suffer the loss of self-esteem accompanying the loss of self-sufficiency. Noninstitutionalized spouses may become impoverished paying the expenses of spouses receiving long-term care.

The lack of interest in long-term care insurance up to now may mean that the financial and other burdens of long-term care are not evident to consumers. Potential purchasers may be underestimating the risks of needing long-term care and may not be completely knowledgeable about the limitations of Medicare and Medigap insurance policies. Effective consumer education programs gradually might diffuse these misconceptions and help potential policyholders better assess the risk of needing long-term care and the role private insurance might play. Consumers need specific information regarding available long-term care financing options, planning for future needs, and the costs of long-term care. Long-term care insurance cannot reach its full potential without educated and aware consumers.

Affordability is also an obstacle to consumer acceptance. While the cost of long-term care insurance always will be too costly for many of the elderly, studies indicate that a larger proportion of the future elderly population will be able to afford long-term care insurance as it is presently sold. One study predicts that the proportion of elderly households with annual real incomes greater than $20,000 will increase from 21 percent in 1980 to 31 percent in 1995.[71]

One solution to the affordability problem is purchase of long-term care insurance at an earlier age, when premiums are lower. A second possible solution may be group insurance, which offers lower premiums because risk is spread over a larger number of persons and adverse selection is reduced. Life insurance and similar capital accumulation vehicles incorporating long-term care insurance options, should they appear on the market, also might be less expensive than currently available exclusively long-term care policies because the premium payments would be spread over a longer time period of time. Barriers to consumer acceptance must be overcome, however, for these more inclusive options to be effective.

The need for consumer protection in long-term care insurance is a recurring theme. Consumer groups, legislators, and government leaders alike have emphasized the importance of insuring that policyholders receive benefits commensurate with premiums paid, and that consumers fully understand the policies they purchase. The question here is what measures are needed to insure that consumers are protected adequately. AARP, speaking on behalf of its members, has taken the following position:

> [States] should encourage the development of a range of private, long-term care insurance products by eliminating legal and regulatory barriers that impede this development. At the same time, states should protect consumers' interests by such actions as prohibiting fraudulent advertising, developing a buyer's guide, and providing public education about long-term care insurance.[72]

State Government

To governments, long-term care insurance offers the possibility of reduced Medicaid expenditures. This option is especially attractive in a time of declining federal financial support and resistance to tax increases. Long-term care insurance alone will not solve the problem of increasing Medicaid budgets, however. Researchers estimate that, at most, a 23 percent maximum decrease in total annual Medicaid expenditures can be expected because of long-term care insurance. Others estimate the impact to be as low as 5 percent annually, on average. Thus, a need always will exist for public funding of long-term care. Long-term care insurance is only one of a number of private and public financing mechanisms that must be developed to create a more accessible, flexible, and efficient long-term care financing system.

At the same time that government seeks to promote the purchase of long-term care insurance, it also must act to assure fair and principled marketing of these policies. Government actions to protect consumers

may focus on the manner in which policies are sold (such as disclosure provisions and "free looks") or their contents. Because the content-related requirements may influence the financial viability of policies, insurers have objected to many of these measures. In some cases, insurers have left states rather than sell policies, leaving little insurance available. State legislatures will have to reconcile the requirements of consumer protection and insurer encouragement, finding a solution that meets each state's unique needs.

The preamble to Georgia Senate Resolution 314 of 1983, creating the Senate Private Long-Term Care Insurance Study Committee, sums up the states' perspective on long-term care insurance:

> . . . . it is projected that one-tenth of the population of Georgia will be age 65 or over by the end of 1985; and
>
> . . . . it is a public policy goal of this state that every senior citizen should have access to quality care; and
>
> . . . . Medicare covers only a maximum of 100 days of care in a skilled nursing facility, provides no coverage for intermediate facility care, and only limited coverage of home health services; and
>
> . . . . most Medigap policies only pay for the deductibles and coinsurance required by Medicare for skilled nursing facility care between the twenty-first and one hundredth day; and
>
> . . . . coverage for comprehensive long-term care services and home health services is offered on a limited basis by only a few companies; and
>
> . . . . long-term expenses may have devastating financial consequences for senior citizens, often forcing them to liquidate assets and exhaust savings until they become eligible for benefits under the Georgia Medical Assistance program; and
>
> . . . . the lack of availability of private insurance for long-term care has resulted in tax supported programs having to bear more than their share of the costs of nursing home services; and
>
> . . . . the health care marketplace is in a state of uncertainty and transition regarding Medicare and coverage for comprehensive long-term care.

States must be concerned about the needs of the growing elderly population and seek ways to meet the financial demands of long-term care. The states' own resources may not be enough, and long-term care insurance should be investigated as one possible alternative.

Notes

1. National Association of Insurance Commissioners Advisory Committee on Long-Term Care, *Long-Term Care: An Industry Perspective on Market Development and Consumer Protection* (exposure draft), (Kansas City, Mo., 1986), p. ii.

2. Ibid., p. 155.

3. Pamela Doty, "Family Care of the Elderly: The Role of Public Policy," *Milbank Quarterly* 64, no. 1 (Spring 1986): 35.

4. U.S. Department of Commerce, Bureau of the Census, *Provisional Projections of the Population of States, by Age and Sex: 1890 to 2000*, Current Population Reports, Series P-25, no. 937 (Washington, D.C., August 1983), Table 2, p. 12.

5. Ibid.

6. Ibid.

7. *Changing Mortality Patterns, Health Services Utilization, and Health Care Expenditures: United States, 1978-2003*, National Center for Health Statistics, Vital and Health Statistics, Analytical and Epidemiological Studies Series 3, no. 23 (Hyattsville, Md., September 1983), Table 8, p. 20.

8. Ibid., based on data in Figure 7, p. 14.

9. Ibid.

10. Changing Mortality Patterns, based on data in Figure 10, p. 16.

11. Larry Lane, personal communication, September 1986.

12. Health Insurance Association of America, "State of Private Long-Term Care Insurance: Results from a National Survey," *Research and Statistical Bulletin*, no. 5-86 (Washington, D.C., 1986), p. 3.

13. Larry Lane, personal communication, September 1986.

14. 1986 Colo. Sess. Laws, Chap. 76.

15. ICF Incorporated, *Private Financing of Long-Term Care: Current Methods and Resources, Phase 1*, Final Report (Washington, D.C., 1985), p. 61.

16. Ibid.

17. Josh Weiner, personal communication, February 1986.

18. Marian Gornick, Jay Greenberg, Paul Eggers, and Allen Dobson, "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," *Health Care Financing Review*, 1985 Annual Supplement, Table 32, p. 49.

19. Daniel Waldo, Katharine Levit, and Helen Lazenby, "National Health Expenditures, 1985," *Health Care Financing Review* 8, no. 1 (Fall 1986): Table 10, p. 20.

20. Ibid.

21. "National Health Expenditures," 1985, p. 19.

22. Martha Riche, "Nursing Home Dilemma," *American Demographics* 7, no. 10 (October 1985): 36.

23. U.S. Congress, House Select Committee on Aging, *Twentieth Anniversary of Medicare and Medicaid: Americans Still at Risk*, Committee Print No. 99-538, 99th Congress, 1st Session (Washington, D.C., 1986), based on data contained in Table 2, p. 57.

24. Ibid.

25. Health Insurance Association of America, "Results from a National Survey," p. 4.

26. Doris Topolnicki, "When a Nursing Home Becomes Your Poorhouse," Money 15, no. 3 (March 1986): 177-182.

27. National Association of Insurance Commissioners, Long-Term Care: An Industry Perspective, pp. 72-75, 90-93.

28. Laventhol and Horwath, Life Care Industry: *Fourth Annual Report of the Life Care Industry in the United States* (Philadelphia, Pa., July 1984), p. 84.

Cited in Life Care Centers: *An Alternative Delivery System for the Elderly* (Washington, D.C.: Office of Health Planning, Health Resources and Services Administration, 1986), p. 2.

29. These two studies are described in Mark Meiners and A. K. Tave, "Consumer Interest in Long-Term Care Insurance: A Survey of the Elderly in Six States" (Washington, D.C.: National Center for Health Services Research, 1984); and Towers, Perrin, Foster, and Crosby, *American Association of Retired Persons Long-Term Care Research Study, Executive Summary* (New York, N.Y., 1984).

30. Meiners and Tave, "Consumer Interest," Tables 3 and 5.

31. Marc Cohen, Eileen Tell, and Stanley Wallack, "Lifetime Risks and Costs of Nursing Home Use Among the Elderly," *Medical Care* 24, no. 12 (December 1986): 1167-68.

32. Cyril Brickfield, "Long-Term Care Financing Solutions Are Needed Now," *American Health Care Association Journal* 11, no. 6 (October 1985): 14.

33. Pamela Doty, Korbin Liu, and Joshua Wiener, "An Overview of Long-Term Care," *Health Care Financing Review* 6, no. 3 (Spring 1985): 72.

34. Waldo, Levit, and Lazenby, "National Health Expenditures," p. 19.

35. Data on Medicare-certified beds in *Medicare Program Statistics: Selected State Data, 1978-82* (Baltimore, Md.: Bureau of Data Management and Strategy, Health Care Financing Administration, 1984), p. 28. Total nursing home beds in *Statistical Abstract of the United States* (Washington, D.C.: Bureau of the Census, 1985), Table 178, p. 111.

36. Meiners and Tave, "Consumer Interest," pp. 6-7.

37. Brickfield, "Long-Term Care Financing Solutions," p. 14.

38. Beverly Foundation, *Public Attitudes About Contingency Planning for Long-Term Health Care Needs*, July 1986, p. 7.

39. Towers, Perrin, Foster, and Crosby, *American Association of Retired Persons Long-Term Care Research Study*, p. 4.

40. Meiners and Tave, "Consumer Interest," p. 13.
41. *The Prime Life Generation: A Report Describing the Characteristics and Attitudes of Americans 50 to 64 Years of Age* (n.p.: American Council of Life Insurance and Health Insurance Association of America, n.d.), Table 45, p. 36.
42. Brickfield, "Long-Term Care Financing Solutions," p. 14.
43. Report of the Mini-Cabinet on Long-Term Care to Governor Bill Sheffield, n.d.
44. Report of the Governor's Private Sector Insurance Task Force on Long-Term Care, January 1986.
45. The General Assembly, Report of the Senate Private Long-Term Care Insurance Study Committee (Atlanta, Ga.: December 1985).
46. Report in response to S.R. 76-1983SLH, October 1984.
47. Lawrence Kirsch and Donna Gruverman, *Regulating Long-Term Care Insurance in Massachusetts: Final Report and Recommendations to Insurance Commissioner Peter Hiam* (Boston, Mass.: Consumer Health Advocates, Inc., June 1986).
48. "Long-Term Care Insurance Model Act," National Association of Insurance Commissioners (Kansas City, Mo., 1987).
49. 1986 Me. Laws, Chap. 648; 1986 Wash. Laws, Chap. 170.
50. "Long-Term Care Insurance Model Act," p. 9.
51. 1986 Minn. Laws, Chap. 397.
52. S 746, A 2005, 1986 Session, New Jersey.
53. HB 3064, 1986 Session, Kansas.
54. 1986 Md. Laws, Chap. 633.
55. 1986 Ky. Acts, Chap. 409.
56. Kansas: HB 3064, 1986 Session; New Jersey: S 746, A 2005, 1986 Session.
57. 1986 Ky. Acts, Chap. 409; 1986 Minn. Laws, Chap. 397; 1986 Wash. Laws, Chap. 170.
58. 1986 Me. Laws, Chap. 648.
59. "Long-Term Care Insurance Model Act."
60. 1986 Ky. Acts, Chap. 409.
61. 1986 N.Y. Laws, Chap. 245.
62. 1986 Colo. Sess. Laws, Chap. 246.
63. H.B. 1925, 1986 Session, Hawaii.
64. Kirsch and Gruverman, *Regulating Long-Term Care Insurance in Massachusetts*, pp. 26-40.
65. National Association of Insurance Commissioners, *Long-Term Care: An Industry Perspective*, Appendix C, pp. 145-156.
66. "Making Wise Decisions for Long-Term Care" (Washington, D.C.: American Association of Retired Persons, 1986).
67. "Long-Term Care Insurance Model Act."
68. The Commonwealth of Massachusetts Special Commission on Elderly Health Care, Finance Recommendations (draft) (Boston, Mass., 1986), unnumbered.
69. AB 2583, 1986 Session, California.
70. "Testimony Submitted by the Health Insurance Association of America Before the California Assembly Aging and Long-Term Care Committee," Health Insurance Association of America, January 23, 1986, p. 5.
71. "Demographic Forecasts: Elderly Incomes," *American Demographics* 6, no. 11 (November 1984): 50.
72. *1987 Federal and State Legislative Policy* (Washington, D.C.: American Association of Retired Persons, 1987), p. 249.

National Conference of State Legislatures

The National Conference of State Legislatures serves the country's 7,461 state lawmakers and their staffs.

NCSL was created in January 1975 from the merger of three organizations that served or represented state legislatures. NCSL is a nonpartisan organization with three objectives:

- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation; and
- To ensure states a strong, cohesive voice in the federal system.

The Conference has an Office of State Services in Denver, Colorado, and an Office of State-Federal Relations in Washington, D.C.

The Foundation for State Legislatures

The Foundation for State Legislatures was established in 1982 to provide a forum for the exchange of views between state legislators and the private sector, and to support the programs and objectives of the National Conference of State Legislatures. It is funded by tax-deductible contributions from individuals, groups, and corporations. It is governed by a Board of Directors consisting of officers and members of the NCSL Executive Committee and executive officers from the private sector.

The Series on State Health Policy Issues

What Legislators Need to Know is a series of booklets on state health policy issues prepared for legislators. *What Legislators Need to Know About Long-Term Care Insurance* is the fourth in this series. Previous booklets examined uncompensated hospital care, medical malpractice, and health data/cost information programs. Booklets may be ordered from: Marketing Department, National Conference of State Legislatures, 1050 Seventeenth Street, Suite 2100, Denver, Colorado 80265, 303/623-7800.

National Conference of State Legislatures

Earl S. Mackey, Executive Director

Denver Office
1050 Seventeenth Street, Suite 2100
Denver, Colorado 80265
303/623-7800

Washington Office
444 North Capitol Street, N.W., Suite 500
Washington, D.C. 20001
202/624-5400